

Kentucky Office of Insurance  
Checklist  
Long-Term Care Riders

GENERAL FILING REQUIREMENTS	REFERENCE	COMMENTS
Rate and form filing requirements	806 KAR 14:005 Section 2	Life, annuity, and viatical settlement form filings shall be accompanied by a Life, Annuity, Credit Transmittal Document, Form L-TD.
	Section 3	An entity may include in a filing for a particular insurance company any number of forms or documents, filed together on a particular date, pertaining to a single line of insurance.
	Section 4	The period of time in which the executive director may approve or disapprove the filing shall not begin until both the filing and appropriate fee are received by the office.
	Section 5	A policy or contract form shall not be used in Kentucky until: (1) It has been approved; and (2) If rates for the form are required by law to be approved, the appropriate rate schedule has been approved.
	Section 6	Each form document, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of each page of the document.
	Section 7	If a filing includes a form which amends, replaces, or supplements a form which has been previously filed and not disapproved, it shall be accompanied by a letter of explanation from the filing entity establishing: (1) All changes contained in the newly-filed form; (2) Any effect the changes have upon the hazards purported to be assumed by the policy; (3) The rates applicable to the policy, if required; and (4) A revised form number.
	Section 8	If a filing is disapproved, the form numbers used on each form within this filing shall not be used on any form of a future filing.
	Section 9	(1) Facsimile signatures of company officers, attorneys-in-fact, employees, and representatives shall not be required and shall not be submitted with any filing. (2) A change of signature of the executing officer on a policy form shall not, because of this change alone, require a new filing.
	Section 10	(1) Life insurance companies may file their rates and forms in an electronic format established by the National Association of Insurance Commissioners, in the manner prescribed by that format. (2) An electronic filing through the National Association of Insurance Commissioners shall substitute for any physical filing.
Minimum standards for the readability and intelligibility of insurance contracts	806 KAR 14:121	Requires a minimum of forty (40) on the Flesch reading ease test. Refer to regulation for specifics.

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Long-term care insurance - rider to life insurance policy or annuity contract	KRS 304.14-600	With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. <b>This is not the complete statute.</b>
Filing requirement for a group policy issued in another state	806 KAR 17:081 Section 17	Prior to an insurer offering group long-term care insurance issued in another state to a resident of Kentucky pursuant to KRS 304.14-610, it shall file with the executive director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in Kentucky.
Initial filing requirements	806 KAR 17:081 Section 7	<p>(2) An insurer shall provide the information listed in this subsection to the executive director in accordance with the time period set forth in KRS 304.14-120(2):</p> <ul style="list-style-type: none"> <li>(a) A copy of the disclosure documents required in Section 6 of this administrative regulation; and</li> <li>(b) An actuarial certification consisting of at least the following: <ul style="list-style-type: none"> <li>1. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately-adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;</li> <li>2. A statement that the policy design and coverage provided have been reviewed and taken into consideration;</li> <li>3. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;</li> <li>4. A complete description of the basis for contract reserves that are anticipated to be held under the form, including: <ul style="list-style-type: none"> <li>a. Sufficient detail or sample calculations to depict completely the reserve amounts to be held;</li> <li>b. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;</li> <li>c. A statement that the net valuation premium for renewable years does not increase, except for attained-age rating if permitted; and</li> <li>d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if the statement cannot be made, a complete description of the situations in which this does not occur. <ul style="list-style-type: none"> <li>(i) An aggregate distribution of anticipated issues may be used if the underlying gross premiums maintain a reasonably consistent relationship;</li> <li>(ii) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection (3) of this section based on a standard age distribution; and</li> </ul> </li> </ul> </li> </ul> </li> </ul>

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		<p>5.a. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or</p> <p>b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.</p> <p>(3) The executive director may request an actuarial demonstration that benefits are reasonable in relation to premiums which shall include premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and creditable data from other studies, or both.</p>
Loss ratio	806 KAR 17:081 Section 15	<p>(4) A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit shall be considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:</p> <p>(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;</p> <p>(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of KRS 304.15-310;</p> <p>(e) An actuarial memorandum is filed with the office of insurance that includes:</p> <ol style="list-style-type: none"> <li>1. A description of the basis on which the long-term care rates were determined;</li> <li>2. A description of the basis for the reserves;</li> <li>3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;</li> <li>4. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;</li> <li>5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;</li> <li>6. The estimated average annual premium per policy and the average issue age;</li> <li>7. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and</li> <li>8. A description of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.</li> </ol>

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Filing requirements for advertising	806 KAR 17:081 Section 18	(1) Every insurer providing long-term care insurance or benefits in Kentucky shall provide a copy of any long-term care insurance advertisement intended for use in Kentucky whether through written, radio, or television medium to the executive director for review or approval by the executive director in accordance with KRS 304.14-620; and
REVIEW REQUIREMENTS	REFERENCE	COMMENTS
Arbitration	KRS 417.050	A written agreement to submit any existing controversy to arbitration or a provision in written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law for the revocation of any contract. This chapter does not apply to:  (2) Insurance contracts. Nothing in the subsection shall be deemed to invalidate or render unenforceable contractual arbitration provisions between two (2) or more insurers, including reinsurers.
Fraud warning	KRS 304.47-030	All applications shall contain a statement in a form approved by the KOI that clearly states in substance the following: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."
HIV and AIDS questions in applications	KRS 304.12-013	An insurer may ask whether an applicant for an insurance contract has tested positive for HIV infection or other health conditions derived from such infection. They may not ask whether the applicant has tested for or has received a negative result.
Life insurance application requirements	806 KAR 12:070	Every application for life insurance solicited personally by an agent shall have the location where the application is signed and the applicant's signature witnessed by the soliciting agent.
Notice of unintentional lapse	806 KAR 17:081 Section 4 (1)(b)	2. The application or enrollment form for the policies or certificates shall clearly indicate the payment plan selected by the applicant.
Privacy of consumer financial information	806 KAR 3:210	The broker or insurer delivers a notice to a consumer when a customer relationship is established on which the following is printed in sixteen (16) point type: "PRIVACY NOTICE-NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW."
Privacy of health information	806 KAR 3:220	The notice of the length of time for which the authorization is valid in no event shall be for more than twenty-four (24) months.

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Prohibition against postclaims underwriting	806 KAR 17:081 Section 8	<p>(1) Applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.</p> <p>(2)(a) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.</p> <p>(3) Except for policies or certificates which are guaranteed issue:  (a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: if your answers on this application, to the best of your knowledge and belief, are incorrect or untrue, (insurer name) has the right to deny benefits or rescind your policy."</p>
Requirements for application forms and replacement coverage	806 KAR 17:081 Section 11	<p>(1)(a) Application forms shall include questions designed to elicit information as to whether:</p> <ol style="list-style-type: none"> <li>1. The applicant has another long-term care insurance policy or certificate in force as of the date of application; or</li> <li>2. A long-term care insurance policy or certificate is intended to replace: <ol style="list-style-type: none"> <li>a. Any other accident and sickness policy or certificate presently in force; or</li> <li>b. Any other long-term care policy or certificate presently in force.</li> </ol> </li> </ol> <p>(b) Except if coverage is sold without an agent, a supplementary application or other form, containing the questions required by this section, may be used if signed by the:</p> <ol style="list-style-type: none"> <li>1. Applicant; and</li> <li>2. Agent.</li> </ol> <p>(c) If a replacement policy is issued to a group, as defined by KRS 304.14-600 (4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the certificate holder has been notified of the replacement.</p> <ol style="list-style-type: none"> <li>1. Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?</li> <li>2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? <ol style="list-style-type: none"> <li>a. If so, with which company?</li> <li>b. If that policy lapsed, when did it lapse?</li> </ol> </li> <li>3. Are you covered by Medicaid?</li> <li>4. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?</li> </ol>

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		(2) Refer to the regulation for the required language for the notice of replacement.
<b>DEFINITIONS</b>		
Adult day care		Means a program for four (4) or more individuals, of social-or health-related, or both, services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.
Assisted-living community	194A.700(3)	Means a series of living units on the same site, operated as one (1) business entity, and certified under KRS 194A.707 to provide services for five (5) or more adult persons not related within the third degree of consanguinity to the owner or manager.
Chronically ill individual		Pursuant to 26 USC 7702B(c)(2), means any individual who has been certified by a licensed health care practitioner within the preceding twelve (12) month period as: (a) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
<b>REQUIRED DISCLOSURE PROVISIONS</b>		
Disclosure of renewability	806 KAR 17:081 Section 5	(1) Renewability:  (a) Individual long-term care insurance policies shall contain a renewability provision. (b) The provision shall: 1. Be appropriately captioned; 2. Appear on the first page of the policy; and 3. State clearly that the coverage is guaranteed renewable or noncancellable. (c) This subsection shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. (d) A long-term care insurance policy or certificate, other than one (1) in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.
Disclosure of tax consequences	806 KAR 17:081 Section 5	(6)(a) A disclosure statement shall be required, as specified in paragraphs (b), (c) and (d) of this subsection, for life insurance policies which provide benefits which are accelerated for long-term care. (c) The statement shall disclose that: 1. Receipt of the benefits may be taxable; and 2. Assistance should be sought from a personal tax advisor. (d) The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

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Nonqualified requirements	806 KAR 17:081 Section 5 (9)	A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, as contained in Section 25 (5)(c) of this administrative regulation, that the policy is not intended to be a qualified long-term care insurance contract.
Qualified requirements	806 KAR 17:081 Section 5 (8)	A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, as contained in Section 25 (5)(c) of this administrative regulation, that the policy is intended to be a qualified long-term care insurance contract under 29 USC 7702B(b).
Required disclosure of rating practices to consumers	806 KAR 17:081 Section 6	<p>(3)(a) A statement that the policy may be subject to rate increases in the future;</p> <p>(b) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option if a premium rate is revised;</p> <p>(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;</p> <p>(d) A general explanation for applying premium rate or rate schedule adjustments that shall include:</p> <ol style="list-style-type: none"> <li>1. A description of when premium rate or rate schedule adjustments will be effective, such as the next anniversary date or next billing date; and</li> <li>2. The right to a revised premium rate or rate schedule as provided in subsection (2) of this section if the premium rate or rate schedule is changed; and</li> </ol> <p>(e)1. Information regarding each premium rate increase on the current policy form or similar policy forms over the past ten (10) years for Kentucky or any other state that, at a minimum, shall identify:</p> <ol style="list-style-type: none"> <li>a. The policy forms for which premium rates have been increased;</li> <li>b. The calendar years when the form was available for purchase; and</li> <li>c. The amount or percent of each increase. The percentage may be expressed as: <ol style="list-style-type: none"> <li>(i) A percentage of the premium rate prior to the increase; or</li> <li>(ii) Minimum and maximum percentages if the rate increase is variable by rating characteristics.</li> </ol> </li> <li>2. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.</li> </ol> <p>3. An insurer may exclude from the disclosure, premium rate increases that occurred prior to the acquisition of and that only apply to:</p> <ol style="list-style-type: none"> <li>a. Blocks of business acquired from other nonaffiliated insurers; or</li> <li>b. The long-term care policies acquired from other nonaffiliated insurers.</li> </ol> <p>4. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers and if those increases occurred prior to the acquisition on or before the later of the effective date of this administrative regulation or the end of a twenty four (24) month period following the acquisition of the block of business or policies, the acquiring insurer may exclude that rate increase from the disclosure.</p>

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		<p>a. The rate increase that may be excluded pursuant to this subparagraph shall be disclosed by the nonaffiliated selling company in accordance with subparagraph 1 of this paragraph.</p> <p>b. If the acquiring insurer files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by this paragraph, including disclosure of the earlier rate increase.</p> <p>(9) The notice required, pursuant to subsection (8) of this section, shall include the information required by subsection (3) of this section when the rate increase is implemented.</p>
<b>OUTLINE OF COVERAGE REQUIREMENTS</b>		
Required standards and disclosures	KRS 304.14-615	<p>(7)(b) The outline of coverage shall include:</p> <ol style="list-style-type: none"> <li>1. A description of the principal benefits and coverage provided in the policy;</li> <li>2. A statement of the principal exclusions, reductions, and limitations contained in the policy;</li> <li>3. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;</li> <li>4. A statement that the outline of coverage is a summary only, not a contract of insurance and that the policy or group master policy contains governing contractual provisions;</li> <li>5. A description of the terms under which the policy or certificate may be returned and premium refunded; and</li> <li>6. A brief description of the relationship of the cost of care and benefits.</li> </ol>
Marketing standards	806 KAR 17:081 Section 19	<p>(1) Every insurer marketing long-term care insurance coverage in this state, directly or through its agents, shall:</p> <p>(b) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."</p>
Payment of benefits	806 KAR 17:081 Section 5 (3)	A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of these terms and an explanation of these terms in its accompanying outline of coverage.
	806 KAR 17:081 Section 5 (8)	A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, as contained in Section 25 (5)(c) of this administrative regulation, that the policy is intended to be a qualified long-term care insurance contract under 29 USC 7702B(b).

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	806 KAR 17:081 Section 5 (9)	A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage, as contained in Section 25 (5)(c) of this administrative regulation, that the policy is not intended to be a qualified long-term care insurance contract.
Standard format outline of coverage	806 KAR 17:081 Section 25	Refer to this section for the required standard format for the outline of coverage.
<b>POLICY SUMMARY REQUIREMENTS</b>		
Required standards and disclosures	KRS 304.14-615	<p>(9) In addition to complying with all applicable requirements, the summary shall also include:</p> <ul style="list-style-type: none"> <li>(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;</li> <li>(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;</li> <li>(c) Any exclusions, reductions, and limitations on benefits of long-term care insurance; and</li> <li>(d) If applicable to the policy type, the summary shall also include: <ul style="list-style-type: none"> <li>1. A disclosure of the effects of exercising other rights under the policy;</li> <li>2. A disclosure of guarantees related to long-term care of insurance charges; and</li> <li>3. Current and projected maximum lifetime benefits.</li> </ul> </li> </ul>
	806 KAR 17:081 Section 15	<p>(4) A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit shall be considered to provide reasonable benefits in relation to premium paid, if the policy complies with all of the following provisions:</p> <ul style="list-style-type: none"> <li>(c) The policy meets the following disclosure requirements: <ul style="list-style-type: none"> <li>2. When the policy is delivered, a policy summary shall be delivered in accordance with KRS 304.14-615(9);</li> <li>3. The policy summary shall state that any long-term care inflation protection option required by Section 10(1) of this administrative regulation is not available under this policy;</li> <li>4. The policy summary required by subparagraph 2 of this paragraph may be incorporated into a basic illustration that meets the requirements of Section 29 of this administrative regulation.</li> </ul> </li> </ul>
<b>REQUIREMENTS FOR LONG-TERM CARE RIDER</b>		
Arbitration	KRS 417.050	A written agreement to submit any existing controversy to arbitration or a provision in written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law for the revocation of any contract. This chapter does not apply to:

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		(2) Insurance contracts. Nothing in the subsection shall be deemed to invalidate or render unenforceable contractual arbitration provisions between two (2) or more insurers, including reinsurers.
Benefit triggers	806 KAR 17:081 Section 5	<p>(7) Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits."</p> <p>(a) Any additional benefit triggers shall also be explained in this section of the policy or certificate.</p> <p>(b) If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description.</p> <p>(c) If an attending physician or other specified person must certify a certain level of functional dependency in order to determine eligibility for benefits, this too shall be specified.</p>
Continuation or conversion	806 KAR 17:081 Section 3	<p>(4) Group long-term care insurance issued in Kentucky on or after the effective date to this administrative regulation shall provide a covered individual with a basis for continuation or conversion of coverage:</p> <p>(a) A policy provision shall provide for continued coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.</p> <ol style="list-style-type: none"> <li>1. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy; and</li> <li>2. The executive director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.</li> </ol> <p>(b) A policy provision shall provide that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.</p> <ol style="list-style-type: none"> <li>1. A converted policy shall be an individual policy of long-term care insurance that provides benefits identical to or benefits determined by the executive director to be substantially similar to or in excess of those provided under the group policy from which conversion is made.</li> <li>2. If the group policy from which conversion is made restricts provision of benefits and services to or contains incentives to use certain providers or facilities, the executive director, in making a determination as to the substantial similarity of benefits, shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.</li> </ol>

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		<p>(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if:</p> <ol style="list-style-type: none"> <li>1. The benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses; and</li> <li>2. The converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.</li> </ol> <p>(h) A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.</p>
Discontinuance and replacement	806 KAR 17:081 Section 3	<p>(5)(a) If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination.</p> <p>(b) Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy shall not:</p> <ol style="list-style-type: none"> <li>1. Result in an exclusion for pre-existing conditions that would have been covered under the group policy being replaced; and</li> <li>2. Vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.</li> </ol>
Extension of benefits	806 KAR 17:081 Section 3	<p>(3)(a) Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.</p> <p>(b) The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period, and all other applicable provisions of the policy.</p>
Free look	KRS 304.14-615 (6)	<p>Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in KRS 304.14-600(5)(a), the applicant is not satisfied for any reason.</p>
Limitations	806 KAR 17:081 Section 5 (4)	<p>If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."</p>

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Limitations and exclusions	806 KAR 17:081 Section 3	<p>(2) A policy shall not be delivered or issued for delivery in Kentucky as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:</p> <ul style="list-style-type: none"> <li>(a) Pre-existing conditions or diseases in accordance with KRS 304.14-615(3)(d);</li> <li>(b) Mental or nervous disorders, but this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;</li> <li>(c) Alcoholism and drug addiction;</li> <li>(d) Illness, treatment, or medical condition arising out of: <ul style="list-style-type: none"> <li>1. War or act of war (whether declared or undeclared);</li> <li>2. Participation in a felony, riot or insurrection;</li> <li>3. Service in the armed forces or auxiliary units;</li> <li>4. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or</li> <li>5. Aviation (this exclusion shall apply only to nonfarepaying passengers);</li> </ul> </li> <li>(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;</li> <li>(f) If a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under 42 USC 1395 et seq. or would be so reimbursable except for the application of a deductible or coinsurance amount; and</li> <li>(g) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.</li> </ul>
Minimum standards for home health and community care benefits in long-term care insurance policies	806 KAR 17:081 Section 9	<p>(1) If a long-term care insurance policy or certificate provides benefits for home health care or community care services, it shall not limit or exclude benefits by:</p> <ul style="list-style-type: none"> <li>(a) Requiring that the insured or claimant would need care in a skilled nursing facility if home health-care services were not provided;</li> <li>(b) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;</li> <li>(c) Limiting eligible services to services provided by registered nurses or licensed practical nurses;</li> <li>(d) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his licensure or certification;</li> </ul>

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		<p>(e) Excluding coverage for personal care services provided by a home health aide;</p> <p>(f) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;</p> <p>(g) Requiring that the insured or claimant have an acute condition before home health care services are covered;</p> <p>(h) Limiting benefits to services provided by Medicare-certified agencies or providers; or</p> <p>(i) Excluding coverage for adult day care services.</p> <p>(2) If a long-term care insurance policy or certificate provides for home health or community care services, it shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefit under the policy certificate, when covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.</p> <p>(3) Home health-care coverage may be applied to the nonhome health-care benefits provided in the policy or certificate if determining maximum coverage under the terms of the policy or certificate.</p>
Other limitations or conditions on eligibility for benefits	806 KAR 17:081 Section 5 (5)	A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in KRS 304.14-615(4)(b) shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
Premiums	806 KAR 17:081 Section 3	<p>(6)(a) The premium charged to an insured for long-term care insurance shall not increase due to either:</p> <ol style="list-style-type: none"> <li>1. The increasing age of the insured at ages beyond sixty-five (65); or</li> <li>2. The duration the insured has been covered under the policy.</li> </ol>
Prohibition against postclaims underwriting	806 KAR 17:081 Section 8	(3)(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate when it is delivered: "Caution: The issuance of this long-term care insurance (policy or certificate) is based upon your responses to the questions on your application. A copy of your (application or enrollment form) (is enclosed or was retained by you when you applied). If your answers, to the best of your knowledge and belief, are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)."
Reinstatement	806 KAR 17:081 Section 4	<p>(2) In addition to the requirement in subsection (1) of this section, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, if lapse occurs, if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.</p> <p>(a) This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, if appropriate.</p>

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		(b) The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.
Renewability	806 KAR 17:081 Section 3	<p>(1) The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 5 of this administrative regulation.</p> <p>(a) A long-term care insurance policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."</p> <p>(b) The term "guaranteed renewable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and if the insurer has no unilateral right to make any changes in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.</p> <p>(c) The term "noncancellable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.</p> <p>(d) The term "level premium" may only be used if the insurer does not have the right to change the premium.</p> <p>(e) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of 26 USC 7702B(b)(1)(C).</p>
Required standards and disclosures; pre-existing condition defined; right to return policy	KRS 304.14-615	<p>(2) A long-term care insurance policy shall not:</p> <p>(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;</p> <p>(b) Contain a provision establishing a new waiting period in the event existing coverage is covered to or replaced by a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or</p> <p>(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.</p> <p>(3)(a) A long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group defined in KRS 304.14-600 (5)(a), shall not use a definition of "pre-existing condition" which is more restrictive than the following: "Pre-existing condition means a condition for which medical services or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person."</p>

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- (b) A long-term care insurance policy or certificate, other than a policy or certificate under a policy issued to a group as defined in KRS 304.14-600(5)(a), shall not exclude coverage for a loss or confinement which is the result of a pre-existing condition unless that loss or confinement begins within six (6) months following the effective date of coverage of an insured person.
- (c) The executive director may extend the limitation periods set forth in subsection (3)(a) and (b) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.
- (d) The definition of "pre-existing condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a pre-existing condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. A long-term care insurance policy or certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection.
- (4)(a) A long-term care insurance policy shall not be delivered or issued for delivery in this Commonwealth if the policy:
1. Conditions eligibility for any benefits on a prior hospitalization requirement;
  2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
  3. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.
- (b) 1. A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" the limitations or conditions, including any required number of days of confinement.
2. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.
- (6) Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in KRS 304.14-600(5)(a), the applicant is not satisfied for any reason.

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		<p>(8) A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in this Commonwealth or a certificate subject to approval by the executive director shall include:</p> <ul style="list-style-type: none"> <li>(a) A description of the principal benefits and coverage provided in the policy;</li> <li>(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and</li> <li>(c) A statement that the group master policy determine governing contract provisions.</li> </ul>
Riders and endorsements	806 KAR 17:081 Section 5	<p>(2) Riders and endorsements</p> <ul style="list-style-type: none"> <li>(a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.</li> <li>(b) After the date of policy issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law.</li> <li>(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.</li> </ul>
Standards for benefit triggers	806 KAR 17:081 Section 23	<p>(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment.</p> <p>(2) Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.</p> <p>(3)(a) Activities of daily living shall include at least the following as defined in Section 2 of this administrative regulation and in the policy:</p> <ul style="list-style-type: none"> <li>1. Bathing;</li> <li>2. Continence;</li> <li>3. Dressing</li> <li>4. Eating;</li> <li>5. Toileting; and</li> <li>6. Transferring;</li> </ul> <p>(b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in paragraph (a) of this subsection if they are defined in the policy.</p> <p>(4) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate and the provisions shall not restrict, and shall not be in lieu of, the requirements contained in subsections (1), (2), and (3) of this section.</p> <p>(5) For purposes of this section the determination of a deficiency shall not be more restrictive than:</p> <ul style="list-style-type: none"> <li>(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or</li> </ul>

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		<p>(b) If the deficiency is due to the presence of a cognitive impairment, needing supervision or verbal cueing by another person in order to protect the insured or others.</p> <p>(6) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.</p> <p>(7) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.</p> <p>(8) A long-term care insurance policy shall cover services as required by KRS 304.14-617.</p>
Standards for benefit triggers for qualified long-term care insurance contracts (additional)	806 KAR 17:081 Section 24	<p>(1) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically-ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.</p> <p>(2) A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.</p> <p>(3) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (2) of this section shall be performed by a licensed health care practitioner.</p> <p>(4) Certifications required pursuant to subsection (2) of this section may be performed by a licensed health care professional at the direction of the carrier if it is reasonably necessary with respect to a specific claim, except that if a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification shall not be rescinded and additional certifications shall not be performed until after the expiration of the ninety (90) day period.</p> <p>(5) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.</p>